		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039800

Facility Name: Casey Care Center

Address: 5 Doctors Park (Number) Mount Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: (618) 242-1064 **Fax #** (618) 242-7559

IDPA ID Number: 391516877001

Date of Initial License for Current Owners: 10/01/94

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser, LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	106	Intermediate (ICF)	106	38,690	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	19,442	7,039		26,481	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,442	7,039		26,481	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.44%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 10/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	99,390	9,249	5,575	114,214		114,214		114,214			1
2	Food Purchase		103,218		103,218		103,218	(14,578)	88,640			2
3	Housekeeping	74,614	9,610		84,224		84,224		84,224			3
4	Laundry	31,064	11,988		43,052		43,052		43,052			4
5	Heat and Other Utilities			53,518	53,518		53,518		53,518			5
6	Maintenance	36,200		25,431	61,631		61,631		61,631			6
7	Other (specify):*											7
8	**TOTAL General Services**	241,268	134,065	84,524	459,857		459,857	(14,578)	445,279			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	859,518	41,306	812	901,636		901,636		901,636			10
10a	Therapy			846	846		846		846			10a
11	Activities	17,865	5,024	1,116	24,005		24,005		24,005			11
12	Social Services	24,265		804	25,069		25,069		25,069			12
13	Nurse Aide Training											13
14	Program Transportation			893	893		893		893			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	901,648	46,330	10,471	958,449		958,449		958,449			16
	C. General Administration											
17	Administrative	46,431		264,000	310,431		310,431		310,431			17
18	Directors Fees							15,155	15,155			18
19	Professional Services			1,927	1,927		1,927	49,549	51,476			19
20	Dues, Fees, Subscriptions & Promotions			9,374	9,374		9,374	472	9,846			20
21	Clerical & General Office Expenses	17,517	4,254	27,580	49,351		49,351	(655)	48,696			21
22	Employee Benefits & Payroll Taxes			114,700	114,700		114,700	76,432	191,132			22
23	Inservice Training & Education			287	287		287		287			23
24	Travel and Seminar			3,805	3,805		3,805	2,091	5,896			24
25	Other Admin. Staff Transportation			1,371	1,371		1,371	1,676	3,047			25
26	Insurance-Prop.Liab.Malpractice							63,152	63,152			26
27	Other (specify):*											27
28	**TOTAL General Administration**	63,948	4,254	423,044	491,246		491,246	207,872	699,118			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,206,864	184,649	518,039	1,909,552		1,909,552	193,294	2,102,846			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Casey Care Center #0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			8,456	8,456		8,456	124,309	132,765			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,703	5,703		5,703	282,533	288,236			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			424,902	424,902		424,902	(424,902)				34
35	Rent-Equipment & Vehicles			3,190	3,190		3,190	70	3,260			35
36	Other (specify):* **Mtge. Insurance**							16,186	16,186			36
37	**TOTAL Ownership**			442,251	442,251		442,251	(1,804)	440,447			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							2,944	2,944			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):* **Nonallowable Costs**			24,425	24,425		24,425	(24,425)				43
44	**TOTAL Special Cost Centers**			82,460	82,460		82,460	(21,481)	60,979			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,206,864	184,649	1,042,750	2,434,263		2,434,263	170,009	2,604,272			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(479)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,980	30		9
10	Interest and Other Investment Income	(5,365)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(11,776)	43		18
19	Entertainment				19
20	Contributions	(70)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,939)	43		24
25	Fund Raising, Advertising and Promotional	(4,274)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Misc. Income Offset	(3,641)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (27,564)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	197,573		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 197,573		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 170,009		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Casey Care Center

ID# 0039800

Report Period Beginning: 07/01/01

Ending: 06/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Casey Care Center **#** 0039800 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	6,314	8,841	0	0	0	0	0	0	0	0	15,155	18
19	Professional Services	0	15,598	20,940	13,011	0	0	0	0	0	0	0	49,549	19
20	Fees, Subscriptions & Promotions	0	100	151	221	0	0	0	0	0	0	0	472	20
21	Clerical & General Office Expenses	0	553	2,393	40	0	0	0	0	0	0	0	2,986	21
22	Employee Benefits & Payroll Taxes	0	0	61,854	0	0	0	0	0	0	0	0	61,854	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	415	1,676	0	0	0	0	0	0	0	0	2,091	24
25	Other Admin. Staff Transportation	0	1,676	0	0	0	0	0	0	0	0	0	1,676	25
26	Insurance-Prop.Liab.Malpractice	0	252	200	62,700	0	0	0	0	0	0	0	63,152	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	24,908	96,055	75,972	0	0	0	0	0	0	0	196,935	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	24,908	96,055	75,972	0	0	0	0	0	0	0	196,935	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Casey Care Center # 0039800 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	5,980	1,714	0	116,615	0	0	0	0	0	0	0	124,309	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,365)	1,911	1,478	284,509	0	0	0	0	0	0	0	282,533	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	(424,902)	0	0	0	0	0	0	0	(424,902)	34
35	Rent-Equipment & Vehicles	0	70	0	0	0	0	0	0	0	0	0	70	35
36	Other (specify):*	0	0	0	16,186	0	0	0	0	0	0	0	16,186	36
37	**TOTAL Ownership**	615	3,695	1,478	(7,592)	0	0	0	0	0	0	0	(1,804)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	2,944	0	0	0	0	0	0	0	0	0	2,944	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(24,538)	0	0	113	0	0	0	0	0	0	0	(24,425)	43
44	**TOTAL Special Cost Centers**	(24,538)	2,944	0	113	0	0	0	0	0	0	0	(21,481)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(23,923)	31,547	97,533	68,493	0	0	0	0	0	0	0	173,650	45

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Caravilla Resident Centers, Inc.		See Attached Related Party Schedule		See Attached Related Party Schedule		
See Attached Schedule 7A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Board fees	$	Center for Residential Management, Inc.	**	$ 6,314	$ 6,314	1
2	V	19	Professional fees		Center for Residential Management, Inc.	**	15,598	15,598	2
3	V	20	Licenses, dues, & subs		Center for Residential Management, Inc.	**	100	100	3
4	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	553	553	4
5	V	24	Travel & seminar		Center for Residential Management, Inc.	**	415	415	5
6	V	25	Vehicle expense		Center for Residential Management, Inc.	**	1,676	1,676	6
7	V	26	Vehicle, fire & liab insurance		Center for Residential Management, Inc.	**	252	252	7
8	V	30	Depreciation		Center for Residential Management, Inc.	**	1,714	1,714	8
9	V	32	Interest expense		Center for Residential Management, Inc.	**	1,911	1,911	9
10	V	35	Vehicle lease		Center for Residential Management, Inc.	**	70	70	10
11	V	39	Ancillary service centers		Center for Residential Management, Inc.	**	2,944	2,944	11
12	V					**			12
13	V								13
14	Total			$			$ 31,547	$ * 31,547	14

** Center for Residential Management, Inc. is Caravilla Resident Centers, Inc.'s parent company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule VII - Related Parties **Related Party Schedule**
Page 6, Section A, Column 2, Related Nursing Homes

Name	Facility Name	City
Progressive Housing, Inc.	Gateway Terrace	Irvington
	Aviston Terrace	Aviston
	Briarbrook Place	East Peoria
	Joshua Manor	Hoyleton
	Terra Estates	Hoyleton
	Park Place	Pana
	Harris Place	East Peoria
	Okawville	Okawville
	Billy Goat Hill	Mt. Vernon
	Country Club Hills (185th St.)	Country Club Hills
	Country Club Hills (Lee St.)	Country Club Hills
	Galaxy	Woodlawn
	Perrine	Centralia
	Troy	Troy
	Western Gardens	Mt. Vernon
	Cardinal	Woodlawn
Residential Centers, Inc.	Lakeview Living Center	Chicago
	Countryview Living Center	Latham
	Sparta Terrace	Sparta
	Taylorville Terrace	Taylorville
	Ellner Terrace	Evansville
Caravilla Resident Centers, Inc.	Mt. Vernon Care Center	Mt. Vernon
	Jeffersonian Care Center	Mt. Vernon
	Casey Care Center	Mt. Vernon

Schedule VII, Related Parties
Page 6, Section A, Column 3, Other Related Business Entities

Name	City	Type of Business
Center for Residential Management, Inc.	Peoria	Management/Holding Co.
Residential Centers, Inc.	Peoria	ICF/DD Provider
Progressive Housing, Inc.	Peoria	ICF/DD Provider
Caravilla Charitable Corporation	Mt. Vernon	Lessor
Caravilla Resident Centers, Inc.	Mt. Vernon	SNF/ICF Provider

See Accountants Compilation Report

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	18	Board fees	$	Caravilla Resident Centers, Inc.	100.00%	$ 8,841	$ 8,841	15
16	V	19	Professional fees		Caravilla Resident Centers, Inc.	100.00%	20,940	20,940	16
17	V	20	Licenses, dues & subscriptions		Caravilla Resident Centers, Inc.	100.00%	151	151	17
18	V	21	Office supplies & telephone		Caravilla Resident Centers, Inc.	100.00%	2,393	2,393	18
19	V	22	Emp. Benefits & payroll taxes		Caravilla Resident Centers, Inc.	100.00%	61,854	61,854	19
20	V	24	Travel & seminar		Caravilla Resident Centers, Inc.	100.00%	1,676	1,676	20
21	V	26	Vehicle, fire & liab. insurance		Caravilla Resident Centers, Inc.	100.00%	200	200	21
22	V	32	Interest expense		Caravilla Resident Centers, Inc.	100.00%	1,478	1,478	22
23	V				Caravilla Resident Centers, Inc.	100.00%			23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 97,533	$ * 97,533	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Caravilla Charitable Corporation	**	$ 13,011	$ 13,011	15
16	V	20	Licenses, dues & subscriptions		Caravilla Charitable Corporation	**	221	221	16
17	V	21	Office supplies & telephone		Caravilla Charitable Corporation	**	40	40	17
18	V	26	Vehicle, fire & liab. insurance		Caravilla Charitable Corporation	**	62,700	62,700	18
19	V	30	Depreciation		Caravilla Charitable Corporation	**	116,615	116,615	19
20	V	32	Interest expense		Caravilla Charitable Corporation	**	284,509	284,509	20
21	V	34	Rent expense	424,902	Caravilla Charitable Corporation	**		(424,902)	21
22	V	36	MIP insurance		Caravilla Charitable Corporation	**	16,186	16,186	22
23	V	43	Penalties		Caravilla Charitable Corporation	**	113	113	23
24	V								24
25	V								25
26	V								26
27	V				**Caravilla Charitable Corporation and Caravilla				27
28	V				Resident Centers, Inc. have the same parent company.				28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 424,902			$ 493,395	$ * 68,493	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Robert Bauer	President	Board Member	None	11,332	2 hrs/mtg.		Board fees	$ 2,668	L18, C8	1
2	Roger Ryan	Vice President	Board Member	None	1,757	2 hrs/mtg.		Board fees	1,443	L18, C8	2
3	William Armstrong	Treasurer	Board Member	None	1,757	2 hrs/mtg.		Board fees	1,443	L18, C8	3
4	Kay Baker	Secretary	Board Member	None	1,757	2 hrs/mtg.		Board fees	1,443	L18, C8	4
5	Ronald O'Daniell	Director	Board Member	None	1,757	2 hrs/mtg.		Board fees	1,443	L18, C8	5
6	Merla Cloud	Recorder	Administrative	None	15,913	2 hrs/mtg.		Board fees	2,487	L18, C8	6
7	Ron Schroeder	Board Member	Board Member	None	14,356	2 hrs/mtg.		Board fees	1,044	L18, C8	7
8	Darrell Boehne	Board Member	Board Member	None	14,356	2 hrs/mtg.		Board fees	1,044	L18, C8	8
9	Edward Childers	Board Member	Board Member	None	14,119	2 hrs/mtg.		Board fees	1,081	L18, C8	9
10	Orland Bauer	Board Member	Board Member	None	9,341	2 hrs/mtg.		Board fees	1,059	L18, C8	10
11											11
12	See Attached Schedule 7A										12
13								TOTAL	$ 15,155		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SCHEDULE 7A **Board of Directors Fees**

	Ron Schroeder	Darrell Boehne	Edward Childers	Bob Bauer	Cora Flota	Orland Bauer	Kay Schuman Johnson	Roger Ryan	Ronald O'Daniell	William Armstrong	Kay Baker	Merla McCloud	Totals
Residential Centers, Inc.													
Lakeview Living Center	3,757	3,606	3,606	3,606								3,606	18,181
Sparta Terrace	415	398	398	398								398	2,006
Ellner Terrace	415	398	398	398								398	2,006
Taylorville Terrace	415	398	398	398								398	2,006
Total RCI	5,000	4,800	4,800	4,800	0	0	0	0	0	0	0	4,800	24,200
Progressive Housing, Inc.													
Aviston Terrace	553	576	553		553	553	282					553	3,623
Harris Place	553	576	553		553	553	282					553	3,623
Briarbrook Place	553	576	553		553	553	282					553	3,623
Joshua Manor	553	576	553		553	553	282					553	3,623
Terra Estates	553	576	553		553	553	282					553	3,623
Park Place	553	576	553		553	553	282					553	3,623
Okawville	207	216	207		207	207	106					207	1,358
Perrine	138	144	138		138	138	71					138	906
Western Gardens	138	144	138		138	138	71					138	905
Galaxy	276	288	276		276	276	141					276	1,811
Billy Goat Hill	276	288	276		276	276	141					276	1,811
Troy	138	144	138		138	138	71					138	906
Country Club Hills - 185th St.	207	216	207		207	207	106					207	1,357
Country Club Hills - Lee St.	101	101	101		101	101	0					101	608
Total PHI	4,800	5,000	4,800	0	4,800	4,800	2,400	0	0	0	0	4,800	31,400
Caravilla Resident Centers, Inc.													
Mt. Vernon				980				871	871	871	871	871	5,338
Jeffersonian Care Center				996				885	885	885	885	885	5,421
Casey Care Center				1,624				1,443	1,443	1,443	1,443	1,443	8,841
Total CRC	0	0	0	3,600	0	0	0	3,200	3,200	3,200	3,200	3,200	19,600
Center for Residential Management, Inc. *	5,600	5,600	5,600	5,600		5,600						5,600	33,600
Total Board of Directors Fees	15,400	15,400	15,200	14,000	4,800	10,400	2,400	3,200	3,200	3,200	3,200	18,400	108,800

* Center for Residential Management, Inc.'s board fees are allocated to each facility.

Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business transactions with the nursing home during the reporting period.

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Center for Residential Management, Inc.
Street Address: 4239 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed days available	207,498	21	$ 7,680	$ 7,680	38,690	$ 1,432	1
2	20	Licenses, dues, & subs	Bed days available	207,498	21	(100)	(100)	38,690	(19)	2
3	21	Office supplies & telephone	Bed days available	207,498	21	(861)	(861)	38,690	(160)	3
4	24	Travel & seminar	Bed days available	207,498	21	(580)	(580)	38,690	(108)	4
5	25	Vehicle expense	Bed days available	207,498	21	8,145	8,145	38,690	1,519	5
6	26	Vehicle, fire & liab insurance	Bed days available	207,498	21	1,353	1,353	38,690	252	6
7	30	Depreciation	Bed days available	207,498	21	9,194	9,194	38,690	1,714	7
8	32	Interest expense	Bed days available	207,498	21	8,154	8,154	38,690	1,520	8
9	35	Vehicle lease	Bed days available	207,498	21	375	375	38,690	70	9
10	39	Ancillary service centers	Bed days available	207,498	21	15,783	15,783	38,690	2,944	10
11										11
12										12
13	18	Board fees	Direct method						6,314	13
14	19	Professional fees	Direct method						14,166	14
15	20	Licenses, dues, & subs	Direct method						119	15
16	21	Office supplies & telephone	Direct method						713	16
17	24	Travel & seminar	Direct method						523	17
18	25	Vehicle expense	Direct method						157	18
19	32	Interest expense	Direct method						391	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 49,143	$ 49,143		$ 31,547	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Caravilla Resident Centers, Inc.
Street Address: 4239 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Board fees	Number of beds	235	3	$ 19,600	$	106	$ 8,841	1
2	19	Professional fees	Number of beds	235	3	46,424		106	20,940	2
3	20	Licenses, dues & subscriptions	Number of beds	235	3	335		106	151	3
4	21	Office supplies & telephone	Number of beds	235	3	5,308		106	2,393	4
5	22	Emp. benefits & payroll taxes	Number of beds	235	3	(567)		106	(224)	5
6	24	Travel & seminar	Number of beds	235	3	3,716		106	1,676	6
7	26	Vehicle, fire & liab. insurance	Number of beds	235	3	400		106	200	7
8	32	Interest expense	Number of beds	235	3	3,276		106	1,478	8
9										9
10	22	Emp. benefits & payroll taxes	Direct method						62,078	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 78,492	$		$ 97,533	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	NCS Healthcare, Inc.		x	Hardware/Software	$728.00	10/31/98	$ 29,136	$ 18,070	01/01/04	0.1429	$ 973	1
2	Continental Wingate		x	Purchase Facility	$55,560.00	09/16/96	7,402,500	3,226,281	10/01/31	0.0855	276,962	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8									Amortization expense		5,711	8
9	TOTAL Facility Related				$56,288.00		$ 7,431,636	$ 3,244,351			$ 283,646	9
	B. Non-Facility Related*											
10							Finance charges				5,275	10
11							Offset on interest income				(1,731)	11
12							Non-allowable finance charges				(5,275)	12
13							Parent company allocation				6,321	13
14	TOTAL Non-Facility Related						$	$			$ 4,590	14
15	TOTALS (line 9+line14)						$ 7,431,636	$ 3,244,351			$ 288,236	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 16,186 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ N/A	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Casey Care Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0039800

CONTACT PERSON REGARDING THIS REPORT Rob Keime

TELEPHONE (309) 685-0595 FAX #: (309) 685-8463

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.	N/A		$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,285 B. General Construction Type: Exterior Block & Brick Frame Brick Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	120,000	1994	$ 110,000	1
2					2
3	TOTALS	120,000		$ 110,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	106		1994	1970	$ 2,025,900	$	40	$ 50,648	$ 50,648	$ 392,521	4
5			1998	1998	6,585		40	165	165	742	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1995	2,586		15	172	172	1,284	9
10	4 doors			1995	715		15	48	48	288	10
11	3 furnaces, 2 a/c's, 3 coils			1995	14,366		15	958	958	5,748	11
12	Windows			1996	20,184		15	1,346	1,346	7,235	12
13	Fire & security alarms			1996	9,560		15	637	637	3,424	13
14	Architecture costs			1996	7,939		15	529	529	2,843	14
15	Asphalt & sidewalk			1996	7,408		15	500	500	2,649	15
16	Roofing			1996	54,022		15	3,601	3,601	19,356	16
17	Fire & security alarm			1997	4,110		15	274	274	1,473	17
18	Paint & wallpaper			1997	3,082		15	205	205	1,103	18
19	Hinges & doors			1997	6,284		15	419	419	2,252	19
20	Tile			1997	10,739		15	716	716	3,848	20
21	Garage & ground prep			1997	10,489		15	699	699	3,757	21
22	Roofing			1997	7,202		15	480	480	2,580	22
23	Handrail			1997	10,900		15	727	727	3,908	23
24	HVAC			1997	27,483		15	1,833	1,833	9,851	24
25	Dryvit			1997	13,900		15	927	927	4,983	25
26	Plumbing & electrical			1997	21,742		15	1,449	1,449	7,789	26
27	Architecture costs			1997	1,986		15	132	132	710	27
28	Flooring			1997	700		15	47	47	211	28
29	Remodeling of facility			1997	18,980		15	1,265	1,265	5,693	29
30	A/C Timer			1997	2,338		15	156	156	702	30
31	Painting			1997	5,792		15	386	386	1,737	31
32	Landscaping			1997	6,430		15	429	429	1,930	32
33	Lockset, passage set			1997	9,104		15	607	607	2,731	33
34	Electrical service			1997	8,704		15	580	580	2,610	34
35	Ceiling Tiling			1997	3,762		15	251	251	1,129	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Doors	1997	$ 8,000	$	15	$ 532	$ 532	$ 2,395	37
38	Remodeling of bathroom	1998	4,149		15	277	277	1,246	38
39	Remodeling of facility	1998	12,277		15	818	818	3,681	39
40	Painting	1998	2,541		15	169	169	761	40
41	Tiling	1998	2,205		15	147	147	662	41
42	Flooring	1998	27,771		15	1,851	1,851	8,330	42
43	Painting and Wallpaper	1998	2,912		15	194	194	873	43
44	Light Fixtures	1998	931		15	62	62	279	44
45	Cabinets/Drawers/Countertops	1998	1,401		15	93	93	419	45
46	Fence	1998	9,613		15	641	641	2,884	46
47	Piping	1998	168		15	11	11	50	47
48	Windows	1998	430		15	29	29	130	48
49	Security	1998	16,030		15	1,069	1,069	4,810	49
50	Architecture Services	1998	270		15	18	18	81	50
51	Signs	1998	3,500		15	233	233	1,049	51
52	Sidewalk	1998	720		15	48	48	216	52
53	Awning	1998	4,937		15	369	369	1,272	53
54	Nurse Station Shelving	1998	541		15	36	36	126	54
55	Landscaping	1998	1,614		15	108	108	378	55
56	Carpeting	1998	1,715		15	114	114	399	56
57	Air Conditioner Enclosures	1998	1,806		15	120	120	420	57
58	Sidewalk	1998	3,621		15	242	242	847	58
59	Beauty Shop Renovation	1998	623		15	42	42	147	59
60	Panic Bar	1998	279		15	19	19	66	60
61	Fountain	1998	290		15	20	20	70	61
62	Alarm Door Controller	1998	325		15	22	22	77	62
63	Light & related renovation	1998	963		15	64	64	224	63
64	Landscaping	1998	3,447		15	230	230	805	64
65	Grab bar, sink	1998	401		15	27	27	94	65
66	Annunciator @ nursing station	1999	2,500		15	167	167	584	66
67	Ceiling Tiles	1999	416		15	28	28	98	67
68	Drywall renovation	1999	1,930		15	129	129	451	68
69	Lavatory	1999	300		15	20	20	70	69
70	TOTAL (lines 4 thru 69)		$ 2,441,618	$		$ 78,135	$ 78,135	$ 529,081	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,441,618	$		$ 78,135	$ 78,135	$ 529,081	1
2	Lavatory	1999	324		15	22	22	77	2
3	Lighting	1999	983		15	66	66	231	3
4	Kitchen cabinets	1999	1,291	86	15	86		301	4
5	Asphalt resurfacing	1999	10,259		15	684	684	2,394	5
6	Door frames & accessories	1999	1,238	83	15	83		208	6
7	Insinkerator	1999	962	64	15	64		160	7
8	Painting and remodeling	2000	13,699		15	913	913	2,283	8
9	Hot water line	2000	2,569	171	15	171		172	9
10	Laundry room remodeling	2000	1,400	93	15	93		94	10
11	Molding	2001	773	51	15	51		77	11
12	Molding	2001	631	42	15	42		63	12
13	A/C condensor	2001	1,445	96	15	96		144	13
14	Labor for building improvements	2000	23,139		15	1,543	1,543	3,086	14
15	Water Heater	2002	2,739	91	15	91		91	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,503,070	$ 777		$ 82,140	$ 81,363	$ 538,462	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 459,086	$ 5,565	$ 47,638	$ 42,073	5-10 Years	$ 276,555	71
72	Current Year Purchases	898		45	45	5-10 Years	45	72
73	Fully Depreciated Assets							73
74	Parent company allocation			1,714	1,714			74
75	TOTALS	$ 459,984	$ 5,565	$ 49,397	$ 43,832		$ 276,600	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident transportation	1997 Ford E150***	1997	$ 21,597	$	$	$	3	$ 21,597	76
77	Resident transportation	1995 Chevy Corsica***	2002	1,522	437	254	(183)	3	254	77
78	Resident transportation	1997 Ford Taurus***	2002	3,044	873	507	(366)	3	507	78
79	Resident transportation	1992 Chevy Van***	2002	2,801	804	467	(337)	3	467	79
80	TOTALS			$ 28,964	$ 2,114	$ 1,228	$ (886)		$ 22,825	80

*** Cost allocated between 3 facilities

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	3,102,018	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	8,456	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	132,765	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	124,309	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	837,887	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease . N/A

9. Option to Buy: [ ] YES [x] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 1,665 Description: Dishwasher-$1,548; Water Cooler-$57; Pressure Washer-$60
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident & Admin	95 Chevy Corsica	$ 83.00	$ 500	17
18	Resident & Admin	97 Ford Taurus	108.00	650	18
19	Resident & Admin	92 Chevy Van	63.00	375	19
20	Parent Company Allocation			70	20
21	TOTAL		$ 254.00	$ 1,595	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	16	$	297	$	16	$ 297	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Mcr B Med Supplies	L39, C8						2,944		2,944	13
14	TOTAL			$	16	$	297	$ 2,944	16	$ 3,241	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 999	$ 999	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,502)	237,422	237,422	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,459	7,459	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prepaid Deposit	7,642	7,642	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 253,522	$ 253,522	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		110,000	13
14	Buildings, at Historical Cost		2,032,485	14
15	Leasehold Improvements, at Historical Cost	13,047	470,585	15
16	Equipment, at Historical Cost	47,427	488,948	16
17	Accumulated Depreciation (book methods)	(23,835)	(837,887)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Investment in subsidiary	2,485	2,485	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 39,124	$ 2,266,616	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 292,646	$ 2,520,138	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 154,760	$ 154,760	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	14,060	14,060	29
30	Accrued Salaries Payable	73,915	73,915	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	617,175	617,175	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	740,535	85,478	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,600,445	$ 945,388	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,010	3,230,291	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,010	$ 3,230,291	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,604,455	$ 4,175,679	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,311,809)	$ (1,655,541)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 292,646	$ 2,520,138	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Casey Care Center
Provider #0039800
June 30, 2002

Schedule 17A

XV. Balance Sheet

Line 36-Other	Operating	After Consolidation
Accrued Expense	(244)	(244)
Resident Credit Balances	(60,056)	(60,056)
Accrued Rent	(655,057)	
Accrued Participation Fees	(14,469)	(14,469)
Trustmark	(6,620)	(6,620)
Accrued Insurance	(4,089)	(4,089)
	(740,535)	(85,478)

See Accountants' Compilation Report

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,568,306)	1
2	Restatements (describe):		2
3	**Prior period adjustment**	694,561	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (873,745)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(318,148)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Parent company allocation**		15
16	Other (describe) **added back in column 7**	(119,916)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (438,064)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,311,809)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,095,109	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,095,109	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,265	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,626	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,891	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	90	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 90	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Schedule 19A	16,025	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,025	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,116,115	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	459,857	31
32	Health Care	958,449	32
33	General Administration	491,246	33
	B. Capital Expense		
34	Ownership	442,251	34
	C. Ancillary Expense		
35	Special Cost Centers	24,425	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,434,263	40
41	**Income before Income Taxes (line 30 minus line 40)****	(318,148)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (318,148)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
A federal tax return is filed for the combined divisions of Caravilla Residents Centers, Inc.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Casey Care Center
Provider #0039800
June 30, 2002

Schedule 19A

XVII. Income statement

Line 28-Other Revenue	**Amount**
Vending Income	766
Miscellaneous Income	3,641
Billing Income	11,618
	16,025

See Accountants' Compilation Report

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,828	1,908	$ 36,409	$ 19.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,177	3,328	50,441	15.16	3
4	Licensed Practical Nurses	16,078	16,958	220,353	12.99	4
5	Nurse Aides & Orderlies	57,806	62,457	466,929	7.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,758	1,933	15,193	7.86	8
9	Activity Director					9
10	Activity Assistants	2,787	2,902	17,865	6.16	10
11	Social Service Workers	2,868	3,048	24,265	7.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,034	15,833	99,390	6.28	15
16	Dishwashers					16
17	Maintenance Workers	3,777	4,169	36,200	8.68	17
18	Housekeepers	11,621	12,455	74,614	5.99	18
19	Laundry	4,989	5,317	31,064	5.84	19
20	Administrator	2,032	2,240	46,431	20.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,744	1,995	17,517	8.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	955	1,021	6,360	6.23	31
32	Other Health Ca See Sch 20A	4,242	4,584	63,833	13.93	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,696	140,148	$ 1,206,864 *	$ 8.61	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	122	$ 5,575	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	717	L10, C3	38
39	Pharmacist Consultant	Monthly	95	L10, C3	39
40	Physical Therapy Consultant	5	160	L10A, C3	40
41	Occupational Therapy Consultant	225	389	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	804	L11, C3	44
45	Social Service Consultant	15	804	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	382	$ 14,544		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Casey Care Center
Provider #0039800
June 30, 2002

Schedule 20A

Schedule XVIII - Staffing & Salary Costs
Line 32 - Other Health Care

Title	Hours Worked	Hours Paid	Amount	Ave. Hourly Wage
Care Plan Coordinator	1,925	2,147	31,247	14.55
Resident Service Director	2,212	2,332	31,859	13.66
Ancillary Clerk	105	105	727	6.92
	4,242	4,584	63,833	13.93

See Accountants' Compilation Report

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ken Cannon	Administrator	0%	$ 25,269
Stephen Hopkins	Administrator	0%	21,162
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 46,431

B. Administrative - Other

Description	Amount
Developmental Services of Illinois, Inc. -	$ 264,000
Administrative Service Fees	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 264,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consulting	$ 1,556
Campbell, Black, Carnine,		
Hedin, Ballard & McDonald	Legal	127
Lawrence Manson	Legal	244
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,927

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,078
Unemployment Compensation Insurance	11,836
FICA Taxes	91,998
Employee Health Insurance	7,098
Employee Meals	14,578
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	3,544
TOTAL (agree to Schedule V, line 22, col.8)	$ 191,132

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,690
Health Care Worker Background Check	742
(Indicate # of checks performed 106)	
Illinois Health Care Association	6,084
Miscellaneous License & Fees	688
Miscellaneous Dues & Subscriptions	240
Parent Company Allocation	202
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,846

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,758
Seminar Expense	3,246
Parent Company Allocation	(108)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,896

* Attach copy of IMRF notifications

**See instructions.

Casey Care Center
Provider #0039800
June 30, 2002

Schedule 21C

XIX. Support Schedules
Section C. Professional Services

TOTAL (agree to Schedule V, line 19, column 3)		**1,927**
Caravilla Charitable Corporation:		
Altschuler, Melvoin & Glasser LLP	Accounting	10,031
American Express Tax & Business Services	Accounting	2,980
Caravilla Residential Centers, Inc.:		
Altschuler, Melvoin & Glasser LLP	Accounting	10,844
American Express Tax & Business Services	Accounting	4,908
Lawrence Manson	Legal	4,231
Crain, Miller & Associates	Legal	577
Carr Korein Tillery	Legal	378
Parent Company Allocation:		
American Express Tax & Business Services	Accounting	2,568
Altschuler, Melvoin & Glasser LLP	Accounting	2,644
Heinold-Banwart	Accounting	4,492
Lawrence A. Manson	Legal	5,896
Total adjustments & allocations		49,549
TOTAL (agree to Schedule V, line 19, column 8)		**51,476**

SEE ACCOUNTANTS' COMPILATION REPORT

Caravilla Residential Centers, Inc.
Legal Fees Allocation
June 30, 2002

Professional Fees:

Lawrence Manson	9,380
Crain, Miller & Associates	1,280
Carr Korein Tillery	838
	11,498

Detailed legal invoice listing:

Lawrence Manson	1,240
Lawrence Manson	1,320
Lawrence Manson	2,280
Lawrence Manson	180
Lawrence Manson	1,880
Lawrence Manson	1,140
Lawrence Manson	240
Lawrence Manson	1,100
Crain, Miller & Associates	1,120
Crain, Miller & Associates	160
Carr Korein Tillery	500
Carr Korein Tillery	338
	11,498

	Mt. Vernon	Jeffersonian	Casey Care	Total
number of beds	64	65	106	235
allocation %	0.27	0.28	0.45	1
Lawrence Manson	2,555	2,594	4,231	9,380
Crain, Miller & Associates	349	354	577	1,280
Carr Korein Tillery	228	232	378	838
	-	-	-	-
	3,131	3,180	5,186	11,498

See Accountants' Compilation Report

Please send copies of desk review and audit adjustments to address on this page
Professional Fees Allocation
June 30, 2002

American Express Tax & Business Services	Accounting	13,626
Altschuler, Melvoin & Glasser LLP	Accounting	14,178
Heinold-Banwart	Accounting	24,092
Lawrence Manson	Legal	31,620
Amount allocated through CRM allocation		83,516

Detailed legal invoice listing

Lawrence Manson	3,260
Lawrence Manson	4,360
Lawrence Manson	1,300
Lawrence Manson	5,600
Lawrence Manson	360
Lawrence Manson	3,420
Lawrence Manson	500
Lawrence Manson	2,540
Lawrence Manson	1,980
Lawrence Manson	2,720
Lawrence Manson	1,700
Lawrence Manson	3,880
	31,620

	Lakeview	Countryview	Sparta	Ellner	Taylorville	Gateway	Aviston	Briarbrook	Harris	Joshua	Terra	Park Place	Perrine	Okawville	WGarden	Galaxy	Cardinal	BGHill	Troy	CCH 185th	CCH Lee St.	Mt. Vernon	Jeffersonian	Casey	TOTAL
bed days available	52,925	-	5,840	5,840	5,840	-	5,840	5,840	5,840	5,840	5,840	5,840	1,460	2,190	1,460	2,920	-	2,920	1,460	2,190	1,638	23,360	23,725	38,690	207,498
Alloc. Percentage	0.255063	0.000000	0.028145	0.028145	0.028145	0.000000	0.028145	0.028145	0.028145	0.028145	0.028145	0.028145	0.007036	0.010554	0.007036	0.014072	0.000000	0.014072	0.007036	0.010554	0.007894	0.112579	0.114338	0.186460	1.000000
American Express Tax & Business Se	3,512	-	387	387	387	-	387	387	387	387	387	387	83	128	80	176	-	176	80	128	92	1,551	1,575	2,568	13,626
Altschuler, Melvoin & Glasser LLP	3,616	-	399	399	399	-	399	399	399	399	399	399	100	150	100	200	-	200	100	150	112	1,596	1,621	2,644	14,178
Heinold-Banwart	6,145	-	678	678	678	-	678	678	678	678	678	678	170	254	170	339	-	339	170	254	190	2,712	2,755	4,492	24,092
Lawrence Manson	8,065	-	890	890	890	-	890	890	890	890	890	890	222	334	222	445	-	445	222	334	250	3,560	3,615	5,896	31,620
	21,339	-	2,354	2,354	2,354	-	2,354	2,354	2,354	2,354	2,354	2,354	575	865	572	1,159	-	1,159	572	865	643	9,419	9,566	15,599	83,516

See Accountants' Compilation Report

Casey Care Center
Provider #: 0039800
06/30/2002

Line 24 Detail:

Education/Seminars	1,249
CNA Education	1,997
Admin Travel	1,451
Admin Lodging	527
Admin Meals	372
Seminar Travel	244
Seminar Meals	90
Seminar Lodging	74
	6,004
Parent Company Allocation	(108)
	5,896

See Accountants' Compilation Report

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11									N/A				
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association-$6,084**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **5,481** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **58,035**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **14,578** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **23%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin & Glasser LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Casey Care Center** **02:25 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	170,009	equal to	170,009	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	288,236	equal to	288,236	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	132,765	equal to	132,765	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	3,260	equal to	3,260	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	846	equal to	846	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	2,944	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	459,857	equal to	459,857	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	958,449	equal to	958,449	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	491,246	equal to	491,246	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	442,251	equal to	442,251	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	24,425	equal to	24,425	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	58,035	equal to	58,035	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	780,492	equal to	859,518	-79,026	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	17,865	equal to	17,865	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	24,265	equal to	24,265	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	99,390	equal to	99,390	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	36,200	equal to	36,200	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	74,614	equal to	74,614	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	31,064	equal to	31,064	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	46,431	equal to	46,431	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	17,517	equal to	17,517	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,206,864	equal to	1,206,864	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	5,575	< or = to	5,575	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	812	< or = to	812	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	804	< or = to	1,116	-312	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	804	< or = to	804	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	46,431	equal to	46,431	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	264,000	equal to	264,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	1,927	equal to	1,927	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	191,132	equal to	191,132	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	9,846	equal to	9,846	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	5,896	equal to	5,896	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	58,035	equal to	58,035	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	14,578	< or = to	76,432	-61,854	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	14,578	equal to	14,578	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	197,573	equal to	197,573	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	3,244,351	equal to	3,244,351	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	110,000	equal to	110,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,503,070	equal to	2,503,070	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	488,948	equal to	488,948	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	837,887	equal to	837,887	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,311,809	equal to	-1,311,809	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-318,148	equal to	-318,148	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	292,646	equal to	292,646	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	99,390	9,249	5,575	114,214	0	114,214	0	114,214
2. Food P	0	103,218	0	103,218	0	103,218	-14,578	88,640
3. Housek	74,614	9,610	0	84,224	0	84,224	0	84,224
4. Laundry	31,064	11,988	0	43,052	0	43,052	0	43,052
5. Heat ar	0	0	53,518	53,518	0	53,518	0	53,518
6. Mainter	36,200	0	25,431	61,631	0	61,631	0	61,631
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	241,268	134,065	84,524	459,857	0	459,857	-14,578	445,279
9. Medical	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursin	859,518	41,306	812	901,636	0	901,636	0	901,636
10a. Ther	0	0	846	846	0	846	0	846
11. Activit	17,865	5,024	1,116	24,005	0	24,005	0	24,005
12. Social	24,265	0	804	25,069	0	25,069	0	25,069
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	893	893	0	893	0	893
15. Other	0	0	0	0	0	0	0	0
16. Total H	901,648	46,330	10,471	958,449	0	958,449	0	958,449
17. Admin	46,431	0	264,000	310,431	0	310,431	0	310,431
18. Direct	0	0	0	0	0	0	15,155	15,155
19. Profes	0	0	1,927	1,927	0	1,927	49,549	51,476
20. Fees,	0	0	9,374	9,374	0	9,374	472	9,846
21. Clerica	17,517	4,254	27,580	49,351	0	49,351	-655	48,696
22. Emplo	0	0	114,700	114,700	0	114,700	76,432	191,132
23. Inserv	0	0	287	287	0	287	0	287
24. Travel	0	0	3,805	3,805	0	3,805	2,091	5,896
25. Other	0	0	1,371	1,371	0	1,371	1,676	3,047
26. Insura	0	0	0	0	0	0	63,152	63,152
27. Other	0	0	0	0	0	0	0	0
28. Total (	63,948	4,254	423,044	491,246	0	491,246	207,872	699,118
29. Total (	1,206,864	184,649	518,039	1,909,552	0	1,909,552	193,294	2,102,846
30. Depre	0	0	8,456	8,456	0	8,456	124,309	132,765
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	5,703	5,703	0	5,703	282,533	288,236
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	424,902	424,902	0	424,902	-424,902	0
35. Rent -	0	0	3,190	3,190	0	3,190	70	3,260
36. Other	0	0	0	0	0	0	16,186	16,186
37. Total (	0	0	442,251	442,251	0	442,251	-1,804	440,447
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	0	0	0	0	0	2,944	2,944
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	58,035	58,035	0	58,035	0	58,035
43. Other	0	0	24,425	24,425	0	24,425	-24,425	0
44. Total S	0	0	82,460	82,460	0	82,460	-21,481	60,979
45. Grand	1,206,864	184,649	1,042,750	2,434,263	0	2,434,263	170,009	2,604,272

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	999	999
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievabl	237,422	237,422
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	7,459	7,459
7. Other Prepaid Expenses		
8. Accounts Receivable-Owner/Related Party		
9. Other (specify):	7,642	7,642
10. Total current assets	-363,653	-363,653
LONG TERM ASSETS		
11. Long-Term Notes Receivat	0	0
12. Long-Term Investments	0	0
13. Land	0	110,000
14. Buildings, at Historical Cos	0	2,032,485
15. Leasehold Improvements, I	13,047	470,585
16. Equipment, at Historical Cc	47,427	488,948
17. Accumulated Depreciation	-23,835	-837,887
18. Deferred Charges	0	0
19. Organization & Pre-Operati	0	0
20. Accum Amort - Org/Pre-Op	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (s	0	0
23. other (specify):	2,485	2,485
24. Total Long-Term Assets	39,124	2,266,616
25. Total Assets	-324,529	1,902,963
CURRENT LIABILITIES		
26. Accounts Payable	154,760	154,760
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients	0	0
29. Short-Term Notes Payable	14,060	14,060
30. Accrued Salaries Payable	73,915	73,915
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	617175	617175
34. Deferred Compensation	0	0
35. Federal and State Income	0	0
36. Other Current Liabilities (sp	740,535	85,478
37. Other Current Liabilities (sp	0	0
38. Total Current Liabilities	983,270	328,213
LONG TERM LIABILITES		
39.Long-Term Notes Payable	4,010	3,230,291
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities	0	0
44.Other Long-Term Liabilities	0	0
45.Total Long-Term Liabilities	4,010	3,230,291
46.Total Liabilities	987,280	3,558,504
47.Total Equity	-1,311,809	-1,655,541
48.Total Liabilities and Equity	-324,529	1,902,963

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,095,109
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	2,095,109
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	0
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	3,265
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	1,626
22. Laundry	0
Subtotal - Other Operating Revenue	4,891
24. Contributions	0
25. Interest and Other Investments Income	90
Subtotal - Non-Operating Revenue	90
27. Other Revenue (specify):	0
28. Other Revenue (specify):	16,025
Subtotal - Other Revenue	16,025
30. Total Revenue	2,116,115
31. General Services	680,120
32. Health Care	1,154,988
33. General Administration	668,561
34. Ownership	144,710
35. Special Cost Centers	60,174
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,749,616
41. Income Before Income Taxes	-633,501
42. Income Taxes	0
43. Net Income or Loss for the Year	-633,501

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Line 16 for mortgage insurance.